Important information to help you complete your Application for First Seniority Membership

Thank you for applying for membership to Harvard Pilgrim's First Seniority Plan. Prior to submitting your application to Harvard Pilgrim for processing, please take the time to complete the entire application. If the application received is incomplete, it may not be processed and may be returned to you for additional information.

Please check off each box to ensure that all of the information is provided:
(please press firmly when filling out the application)

- ❑ Your full legal name as it appears on your Medicare Card
- ❑ Your social security number
- ❑ Your date of birth
- ❑ Your gender
- ❑ Your home address (street where you reside)
- ❑ Your telephone number
- ❑ Your emergency contact information
- ❑ Your First Seniority Primary Care Physician (PCP). If a First Seniority PCP is not selected, one will be automatically assigned to you.
- ❑ Read and complete numbers 1 - 7.
- ❑ Your Medicare information. (In order for your enrollment form to be complete, you must either **copy** information from your Medicare card or you may attach a **copy** of your Medicare card or your letter of Verification from the Social Security Administration or Railroad Retirement Board. If you don't have your Medicare information or have not been assigned a Medicare claim number at this time, call your local Social Security Office to enroll or to obtain proof of enrollment.)

Please turn the application over and read each statement carefully and then:

- Sign and date the front of the application. If your Legal Guardian or your Durable Power of Attorney signs this application, a copy of the legal documentation is required.
- If you required assistance in completing this application, please include the assisting individual's signature and relationship.

Detach the pink copy of this form for your records; return your application as follows:

- For Individual enrollment, mail to:
  First Seniority Enrollment Billing, Harvard Pilgrim Health Care
  1600 Crown Colony Drive, Quincy, MA 02169-9777.
- For Employer Group-sponsored enrollment:
  Please ask your employer where you should mail this application (please make sure the name of your Employer is indicated on the application)

Note: If you have End Stage Renal Disease (ESRD), you cannot enroll in this plan unless you are already enrolled in a Harvard Pilgrim plan as a commercial member or you were affected by the non-renewal of another Medicare+Choice plan after December 31, 1998. If you have had a successful kidney transplant, please attach a note or records from your doctor showing you have had a kidney transplant and no longer need regular dialysis.

If you need assistance or have questions, please call us at 1-800-779-7723, TTY/TDD 1-888-259-8276.
Hours of operation are 8 a.m. - 5:30 p.m. Monday – Friday.

FIRST SENIORITY®

Harvard Pilgrim Health Care | Harvard Pilgrim Health Care of New England

Making great health care a little easier.℠

GROUP FIRST SENIORITY

FOR INTERNAL USE ONLY

ID NUMBER
H P F

❑ ENROLLMENT _____ Effective Date

❑ TERMINATION _____ Last Day of Coverage

❑ ADJUSTMENT _____ Effective Date

NAME First Middle Last	Social Security # – –	Date of Birth MO DAY YR	Sex ❑ M ❑ F
PERMANENT ADDRESS # Street Apt # City State Zip County		Applicant's Home Phone # ( )	
EMERGENCY CONTACT Name Relationship	Emergency Contact's Home Phone # ( )	Emergency Contact's Work Phone # ( )	
First Seniority PCP's name:	Are you a regular patient of this doctor? ❑ Yes ❑ No	**PCP #**	**GROUP #** | | | | | | **DIVISION #** | | | |

1. Who is the employer providing you this coverage: _____
2. Do you have End Stage Renal Disease (ESRD)? ❑ Yes ❑ No
   ESRD is permanent kidney failure and requires kidney dialysis or a transplant to stay alive.
3. Do you receive Medicaid benefits? * ❑ Yes ❑ No
   If yes, Medicaid Number: _____
4. Are you currently a member of a Harvard Pilgrim Health plan? ❑ Yes ❑ No
   Member ID #:_____
5. Are you a resident in an institution (e.g. skilled nursing facility, rehabilitation hospital)? * ❑ Yes ❑ No
   If Yes, Name of Institution: _____ Your Date of Admission
   Telephone # of Institution:_____ into Institution: _____
6. Do you or your spouse currently work full-time? ❑ Yes ❑ No
7. Will you have any health insurance in addition to First Seniority? ❑ Yes ❑ No

Health Insurance

SOCIAL SECURITY ACT

Name of Beneficiary _____

_____–_____–_____–__

Medicare Claim Number

SEX ❑ M ❑ F

IS ENTITLED TO EFFECTIVE DATE

Hospital (Part A) ____ ____ ____

Medical (Part B) ____ ____ ____

*Your answer to these questions will not affect your eligibility to enroll.

I understand that my signature on this application certifies that I have read and understand the contents of this application. I also understand that my signature on this application certifies that I have read and understand the contents on the back of this application (Please refer to the First Seniority Benefit Handbook for a written copy of the rules you must follow in order to receive coverage under this First Seniority contract.)

APPLICANT OR LEGAL GUARDIAN SIGNATURE (if applicable) Documentation Required - Please see item "I" on the reverse. | Date | Individual assisting (if applicable) in completion of this application | Relationship | Date

White - First Seniority

Pink - Applicant - Please keep for your records cc1888

A. **Release of Information:** By joining this plan, I allow the Centers for Medicare & Medicaid Services (CMS) to give information to the plan. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B). I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give CMS or CMS's agents the information needed to run the Medicare program.

B. I understand I must keep my **Medicare Part A and Part B insurance** by paying the Part B premiums and the Part A premiums, if applicable.

C. Lock-in:
I understand that, beginning on the date my First Seniority coverage begins, I must get all of my health care from First Seniority providers, with the exceptions of emergency or urgently needed services or out-of-the-area dialysis services.

I understand that services authorized by First Seniority and other services contained in my First Seniority Evidence of Coverage document (also known as the Benefit Handbook) will be covered. I also understand that without authorization, NEITHER MEDICARE NOR FIRST SENIORITY WILL PAY FOR THE SERVICES.

I understand that my First Seniority PCP will help to coordinate my health care and will refer me for specialty care and other care that he or she cannot provide to me directly.

D. First Seniority will send me final approval of my enrollment in the plan. I understand that I should not disenroll from **any Medicare supplement plan or Medigap/Medicare Select Plan** until I get that approval from First Seniority.

E. I understand that as a First Seniority member I am responsible for paying premiums and copayments. (If I am enrolled through my employer, my employer may pay the premium.)

F. I understand that I can be a member of only **one Medicare+Choice plan at a time**. By enrolling in First Seniority, I will automatically be disenrolled from any other Medicare+Choice plan of which I am currently a member.

G. I understand that since I can be a member of only one Medicare+Choice plan at a time, **I cannot enroll in more than one Medicare+Choice plan** with the same effective date of coverage. If I do this, my enrollments will be cancelled and I will have to fill out a new enrollment form to become a member of a Medicare+Choice plan.

H. I understand that I may disenroll from First Seniority by sending a written request to Harvard Pilgrim, the Social Security Office, or the Railroad Retirement Board. The disenrollment will be effective on the last day of the month in which Harvard Pilgrim, the SSA or the Railroad Retirement Board receives my signed written request. Until the effective date of disenrollment, I must continue to receive health care from First Seniority providers.

I. If the beneficiary is unable to sign this form, a court-appointed Legal Guardian or person having Durable Power of Attorney for Health Care (DPAHC) or designated in a written advance directive, if authorized by state law, must sign on the signature line. A copy of the proof of Legal Guardian, DPAHC, written advance directive, or proof of authorization by state law must be attached.

J. I understand that as a member of the plan, I have the right to **ask about the plan's decision** about payment or services if I disagree.

K. I understand that it is my responsibility to tell the plan before I **move** out of the service area. I understand that if I move permanently out of the service area, Medicare requires the plan to disenroll me.

Medicare+Choice contracts between the federal government and HPHC are valid for one calendar year. The benefits, premiums, copayments and service areas offered by HPHC are subject to change on an annual basis. Most Medicare beneficiaries can join, including those eligible on the basis of disability.